0K

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

About You

Subscriber Name: _____

Address: _____

Subscriber ID Number: _____ **Telephone Number:** _____

Member Name: _____ **Date of Birth:** _____

Please place a check mark in front of each plan you want this Accounting of Disclosure request to be applied:

- ☐ GEHA Health Plan
- ☐ GEHA Connection Dental Federal Plan
- ☐ Connection Dental *Plus* Plan
- ☐ CONNECTION Vision Plan

Accounting Request

I request an accounting of how my protected health information was disclosed by GEHA or a Business Associate of GEHA as required by federal regulations.

I want an accounting of disclosures that covers the following time period: _____

Please send my accounting to the following address: _____

Signature and Acknowledgement

I understand that GEHA does not have to tell me about the following types of disclosures:

- Disclosures for purposes of treatment, payment, and healthcare operations;
- Disclosures to me, my personal representative, or authorized by me;
- Disclosures to persons involved in my care;
- For national security or intelligence purposes, to correctional institutions, or to law enforcement officials under certain circumstances;
- As part of a limited data set when the recipient has executed a data use agreement; and
- Disclosures incident to a use or disclosures otherwise permitted or required by law.

I also understand that my right to an accounting or some or all disclosures may be suspended by the government under limited circumstances.

I understand that GEHA must give me the accounting of disclosures within 60 days, or tell me that an extra 30 days (or less) is needed to prepare it.

Date: _____

Signature: _____

Relationship (if not member): _____

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED TO:

ATTN: Accounting of Disclosures
GEHA
P.O. Box 21542
Eagan, MN 55121
FAX: 816.257.3283